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ABSTRACT

This research examined whether a multicomponent program consisting of individual and family counseling intervention for spouse caregivers of Alzheimer's disease patients can affect caregiver depression. Self-referred spouse caregivers (N=52) completed an intensive assessment battery on their perception of patient and personal status at entry into the program and again at a 4-month follow-up. Measures assessed changes in depression, social network satisfaction, physical health, coping resources, and unpaid help. After treatment at 4 months, 26 caregivers improved, 18 worsened, and 8 showed no change on outcome measures. There was a significant bidirectional relationship between change in depression and change in social network satisfaction. Depression level at intake was related to depression level at 4-month follow-up and both were related to change in social network satisfaction. Change in social network satisfaction predicted change in coping behaviors and the resources used. Change in unpaid help from family, friends, and neighbors also predicted change in social network satisfaction. These findings suggest that the multicomponent intervention helps the less depressed caregiver experience improvement in social network satisfaction, coping behaviors, utilization of resources, and feeling of depression. (Author/BHK)

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RELATIONSHIP BETWEEN COPING STRATEGIES AND DEPRESSION
IN CAREGIVERS OF ALZHEIMER PATIENTS

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Abstract

This research examined whether a multicomponent program consisting of individual and family counseling intervention for spouse caregivers of AD patients can affect caregiver depression. There was a significant bidirectional relationship between change in depression and change in social network satisfaction. Depression level at intake was related to depression level at four-month follow up and both were related to change in social network satisfaction. Change in social network satisfaction predicted change in coping behaviors and resources used. Change in unpaid help from family, friends and neighbors also predicted change in social network satisfaction. These findings indicate that the multicomponent intervention helps the less depressed caregivers experience improvement in social network satisfaction, coping behaviors, utilization of resources and feelings of depression.

Key Words: Network satisfaction, Spouse caregivers, Counseling intervention, Unpaid help, Social support

INTRODUCTION

The goals of this study are to support the caregiver and to delineate which caregivers benefit most from treatment. A confluence of changing roles, unpredictability, lack of control and losses, along with chronic stress, threaten the AD caregiving spouse. Depression, which limits one's sense of control and coping resources, has been reported to have a prevalence as high as 87% in AD caregivers by Rabins et. al. (1985) and has been found by many to produce chronic, pervasive demoralization and often, difficult to evaluate depressive symptoms (Schulz et. al, 1989, Stone et. al, 1987; Thompson et al, 1989; Fiore et. al, 1986; Coppel et. al, 1985; Becker & Morrissey, 1988). Cumulative and overwhelming experiences of anticipated bereavement, fatigue, social limitations, social network crisis, financial and psychological uncertainty and stress contribute to higher than normative rates of elderly depression and feelings of helplessness (Blazer et. al, 1989; Zarit et. al, 1986; Fiore et. al, 1983; Gallagher & Czirr, 1984)

Multiple dimensions, causes and individual differences help account for high depression levels in this population. Their depression has been attributed to individuals' cognitive and coping styles, financial and social resources, physical and mental health, and perceptions of support and self-efficacy in dealing with this unplanned, late-life crisis (Cobb, 1976; Levine et. al., 1983; Haley et. al., 1987; Clipp & George, 1990; Poulshock & Deimling, 1989; Gallagher et. al., 1989; Pearlin et. al., 1989; Krause 1986; Blazer et. al., 1989; Vitaliano et. al., 1989; Gallagher, 1990). Lazarus & Folkman (1984) find problem-solving instead of emotion focused coping reduces depression.

The variables examined were found to be highly interactive and confounded. A review of the literature confirms these findings (Turner, 1981; Zarit et al., 1985; Coppel et al., 1985). Essex and Klein (1989) have found self-concept and coping responses reciprocal with physical and mental health confidence. Others have found strong social support, bonds and integration, and active coping to interact with severity of depression (Krause, 1987; Turner, 1981; Pearlin et. al., 1989; Schulz et. al., 1989; Zarit, 1989). Moreover, caregiving demands and feelings of vulnerability are not static; they, along with depressive symptoms change with the illness (Zarit et. al., 1986; Lichtenberg et. al., 1989) Poulshouck and Deimling (1989) believe the complexities of the Alzheimer caregiving role and depression to be cyclically confounded.

More depressed and less socially skilled caregivers lack adaptive repertoires and experience periods of combined negative affect which engender negative coping behaviors, neediness, social withdrawal and limited social support (Fitting et. al., 1986; Stommel et. al., 1990; Clipp & George 1990; Ory et al., 1990). Pruchno and Resch (1989) found a bidirectional relationship between emotion-focused coping which temporarily reduces inner stress, involves emotional reactions, withdrawal, substance and eating abuse and high depression in AD caregivers. Kahn et. al. (1985) report that family group treatment only helped non-clinically depressed caregivers feel more confidence and less depressed. These findings help to account for low treatment effects in our more depressed group of caregivers.

A cognitive model of depression views more depressed persons as asking for more help and experiencing more upsetting experiences and unmet

expectations because of their insatiable, unmet needs and inability to acknowledge support (Beck, 1967; Fiore et. al., 1983). In severely depressed caregivers loneliness may be a life-long trait exacerbated by the social isolation of the illness; these individuals reported less social interaction and concern about lack of ties (Henderson et. al., 1986). Others report internal control attributions, along with self-blame, add to the unpredictability of the disease and create depressive thoughts, which predict negative changes in perception and depression over time (Pagel et. al., 1985). Even with objective social support controlled, at risk caregivers were found to subjectively need more support and satisfaction (George & Gwyther, 1986).

There appear to be personal and social filters that affect perception of environmental and emotional support, which facilitate the coping strategies and experiences for those who are socially malleable (Turner, 1981; Pearlin et. al., 1981, Zarit et. al., 1986; Haley et. al., 1987). Although many studies document a reciprocal and difficult to measure relationship between the experience of social support and actual support, perception of adequate support mediates the uncontrollable strains associated with caregiver depression (Pearlin et. al., 1981; Fiore et. al., 1983; Gwyther & George, 1989).

Formal and informal social supports, education and active, problem solving coping have been shown to cushion life-negative events and prevent future psychiatric symptoms (Williams et. al. 1986; Cobb, 1986). Some aspects of coping are not affected by strategy but by personality, emotional focus and previous depression, so cognitive and behavioral coping techniques are needed to defend against despair and multiple stressors (Pruchno & Resch, 1989).

Coping behaviors that are palliative require multiple resources and energy and provide information, feedback, reframing, bolstering of self-confidence and new repertoires (Pratt et. al., 1984; Wright et. al., 1987; Boss et. al., 1990). Social support and active coping have been found to reduce depression under two conditions: when the social support is both formal and informal and when the range and intensity of the stressors are objectively and subjectively manageable (Pearlin et. al., 1989).

Most caregivers experience varying degrees of physical, psychological and social dysfunction which is created by situational demoralization and reaction to stressors with inadequate coping skills and negative feelings. Therefore, in the present study functional coping was underscored in an intervention program, since caregiver depression and negative affect seem to be leading causes of Alzheimer institutionalization (Daniels & Irwin, 1990). A multicomponent treatment approach included: internal strategies to reframe meaning and manage patient behavior, through individual and family counseling, interaction, planning and communication, and external strategies to help caregivers actively cope using spiritual, community and informational resources. This study of an intervention to improve caregiver well-being and prevent or forestall patient institutionalization has examined 52 caregivers, four months after baseline. Measures assessed change in depression, social network satisfaction, physical health, coping resources and unpaid help.

METHOD

Sample

The sample of 52 self-referred, spouse caregivers who were randomly assigned to the intervention study from the first 109 subjects in an ongoing

treatment-control study. These primary caregivers were carefully screened as living with a clinically diagnosed AD patient, having at least one close relative in the New York City metropolitan area and not receiving formal counseling or group support. At the time of this analysis, 52 treatment subjects had received four-month follow-up evaluations.

Of these subjects, 25 were male, 27 female. The majority of subjects (70%) were between 60-79, with 15% between 80-89 and 15% between 50-60. Most (78%), were involved in patient care for less than three years, with 22% involved for four to ten years at entry. Contrary to the literature, less than 10% were severely depressed, under the normative elderly estimates (Blazer & Williams, 1980). Half of the patients (50%) were evaluated moderately impaired on the Global Deterioration Scale (GDS = 4; Reisberg et al., 1982); 35% were moderate to severely impaired (GDS = 5) and 15% severe (GDS = 6).

Procedures

At entry into the program, caregivers completed an intensive assessment battery on their perception of patient and personal status. They agreed to participate in periodic reassessments at 4, 8, and 12 months, and every six months, thereafter. Subjects, then randomly selected for treatment, agreed to participate in two individual and four family sessions and to join an AD caregiver support group after family sessions. During this first four-month segment, caregivers and family members discussed problems specific to each family and charted individual support plans. The counselor guided in resolving misconceptions, conflicts and negative feelings related to the illness, patient care, problems and changes in the family structure. Patient

limitations, behavior problems and negative feelings were explored. Alternative supportive strategies were generated by each family. Practical (legal, financial and social service) concerns were resolved. The caregiver attended a final session alone, to work on unresolved problems.

Assessment Instruments

Caregiver physical health was assessed with a questionnaire adapted from the OARS (Center for the Study of Aging and Human Development, 1978). Caregiver depression was measured by the Affective Rating Scale (Yesavage, Brink & Rose, 1983). Since caregivers often suffer from isolation, social network satisfaction was assessed by Stoke's Social Network Scale (Stokes, 1983). A comprehensive Caregiver Questionnaire developed by this center included demographic and resource utilization questions, along with inquiries about the amount of unpaid help (such as frequency of visits, patient sitting and telephone calls) on a five-point scale with responses from "daily" to "never." The coping resource section of the questionnaire was a compilation of professional advise (clergy, physicians, lawyers), personal supports (friends, family, work) and community services sought (respite care, custodial care and daycare).

Analysis

First, a set of factor analyses were performed to reduce the number of variables and obtain more reliable measures for coping resources, unpaid help and social network satisfaction. Factor analyses were performed on baseline measures for 180 cases, with reliabilities blind blocked. Reliabilities were calculated with alpha = .81, .49, and .83 for social network satisfaction, coping resources and unpaid help, respectively.

Next, hierarchical multiple regression analyses were run on the dependent variables: social network satisfaction, depression and coping resources, which evaluated treatment effects. The first predictor variable entered into each analysis was the baseline of the dependent variable so as to explain in subsequent steps change at follow-up predicted by each of the five independent variables (physical health, depression, social network satisfaction, unpaid help and coping resources). Squared correlations (R^2) are presented (Table 1) because they represent the additive contribution of each independent variable in explaining the variance in the dependent variable.

RESULTS

Which caregivers on which dimensions benefitted most from this multicomponent counseling intervention? After treatment at four months, 26 spouse caregivers improved, 18 worsened and 8 showed no change on outcome measures.

Follow-up Depression: Change in depression predicted change in social network satisfaction ($\Delta R^2 = .055$, $p < .05$ [Table 1]); their significant bidirectional relationship was the main interaction. Analysis of ARS (Yesavage et al., 1983) scores showed a relationship between initial and follow-up depression levels; those who were less depressed at baseline were less depressed at four months. The subjects who became less depressed experienced more positive change in social satisfaction, affecting their ability to use coping resources and elicit unpaid help.

Follow-up Social Network Satisfaction: Change in social network satisfaction predicted change in depression ($\Delta R^2 = .047$, $p < .05$) and coping resources

($\Delta R^2 = .044$, $p < .05$ [Table 1]). Change in the amount of unpaid help from family, friends and neighbors predicted change in social network satisfaction. Analysis of Stoke Social Network Scale (Stokes, 1983) indicates a high correlation between initial and four month satisfaction with social network.

Follow-up Physical Health: Physical health was not found to predict change in the variables examined.

Follow-up Coping Resources: Initial coping resource utilization predicted the number of coping resources at four months ($\Delta R^2 = .041$, $p < .001$ [Table 1]). This problem-solving style of coping was predicted by change in social network satisfaction ($\Delta R^2 = .044$, $p < .05$ [Table 1]). Coping as an intervening variable affected change in depression.

Follow-up Unpaid Help: Change in unpaid help predicted change in social network satisfaction ($\Delta R^2 = .083$, $p < .01$ [Table 1]).

DISCUSSION

The outcome data were generally consistent with past research on interactive models of caregiver stress, depression, coping and social network satisfaction. Within the group differences emerged as a result of treatment. After four months, there were positive, negative and neutral outcomes. Comprehensively, the counseling intervention included attention to caregiver cognition, problem solving, social support and education, consistent with clinical recommendations (Zarit et al., 1985). The treatment's attention to caregiver and family appraisals of patient behavior, feelings of competence, behavioral responses, misconceptions about the disease, problems, and planning specific course of action influenced spouse caregiver depression, social network satisfaction, the amount of unpaid help, coping resources and

depression. Those initially less depressed and more socially satisfied caregivers enhanced their abilities to mobilize resources and coping strategies and experience well-being because of treatment.

The current findings' bidirectional relationship of change in depression and change in social network satisfaction establishes a causal relationship upon which the other variables interacted or intervene. Since baseline depression and social network satisfaction predicated outcome on these measures, these separate constructs imply entrenched patterns. The findings show that to the extent that caregivers are less depressed, they will have more energy and psychological resources for social interaction and coping responses. Spouse caregivers in the study, whose depression improved, may have been sufficiently socially integrated and skilled to elicit unpaid help, as a result of cyclical social satisfaction and resourceful coping. Revisions in the amount, frequency and responsibilities of unpaid help should give caregivers more free time and foster social integration and bonding, increasing satisfaction with support. Social network satisfaction has been shown in the literature to reflect perceptions of met needs and expectations rather than actual support, unmet perceptions induce negative cycles of depression, neediness, dissatisfaction and dysfunction (Fiore et al., 1983; George & Gwyther, 1986). There may be a feedback loop; wherein more needy and depressed caregivers ask for unreasonable amounts of help and have a greater likelihood of experiencing more unmet expectations and stress. Current findings indicate the less depressed caregivers who elicited more unpaid help from family, friends and neighbors enhanced existing positive feelings of satisfaction and support, which facilitated their use of more coping resources

and, cumulatively, decreased depression created by stress.

This study did not explore the precipitating factors of initial depression. In general, AD caregivers suffer from social network crises; they have lost their ill spouse and can experience ongoing depression (Krause, 1987). Prior research on caregiver depression has been linked to prior depressive thoughts, loss of control, negative subjective appraisals and learned helplessness (Pagel et al., 1985; Haley et al., 1987). Current results indicate positive change found in follow-up depression is attributed to treatment effects that supported self-efficacy, feelings of control, social support, communication, problem-solving responses, education and information. Past research suggests that more depressed caregivers do not have the cognitive and behavioral flexibility, social skills and integration to use respite resources available which influence chronic stress created by the illness (Becker & Morrissey, 1988). The more depressed in this study have not been helped by this short counseling intervention to break this negative cycle.

This research underscored that caregivers have different coping systems, a mix of personal coping strategies, formal and informal supports. Lazarus and Folkman (1984) offer a model of two styles of coping: problem-solving focused and emotion focused. This intervention study encouraged problem-solving coping, information and help-seeking, planning alternatives, and/or changing existing difficulties, which clinical studies associate with lower caregiver depression (Mitchell et al., 1983; Dohrenwend & Dohrenwend, 1978). Current research findings show increased use of coping resources predicted by social network satisfaction is inseparable from the situational

context in which it occurs. The more functional caregivers improve more. Theoretically, treatment effects on social support may bolster certain caregivers feelings of competence and control, fostering active coping responses and lowering depression (Krause, 1987; Gallagher et al., 1990).

Although the present intervention program benefitted half the subjects, many unanswered questions remain. Questions arise about personality structure and differences that can predict well-being. How can the more depressed, more socially dissatisfied caregivers be optimally treated? More needs to be known about the specific nature of AD caregiver depression. More contextually precise measures need to be developed to relate specific stressors to affective disturbance. Different interventions should be tried to see who has the best response to which type of treatment. This study addresses the unexplored area of efficiently treating subgroups of spouse caregivers. Depression, a treatable condition, was found to be an antecedent and predictor of a pattern of social network satisfaction, coping responses, and social support.

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Table 1
Hierarchical Regression Analysis of the Effects of Treatment on Follow-Up Social Network Satisfaction
Depression, and Coping Resources

Independent Variables	Dependent Variables					
	Follow-Up Social Network Satisfaction		Follow-Up Depression		Follow-Up Coping Resources	
	ΔR^2	F	ΔR^2	F	ΔR^2	F
Social Network						
Baseline Satisfaction	.459	42.4***	.002	0.1	.004	.29
Social Network						
Follow-Up Satisfaction			.055	5.0*	.044	4.0*
Baseline Depression	.044	4.3*	.418	36.0***	.005	.40
Follow-Up Depression	.047	5.0*			.015	1.26
Baseline Coping Resources	.001	0.1	.027	2.68	.413	3.53***
Follow-Up Coping Resources	.019	1.9	.012	1.26		
Baseline Unpaid Help	.014	1.5				
Follow-Up Unpaid Help	.083	10.5**				
R^{2+}	.668		.565		.486	

ΔR^2 = Variance explained by the entry of the indicated variable into the model.

* = $p < .05$; ** = $p < .01$; *** = $p < .001$

⁺ R^2 = Amount of variance explained by the entire model.